STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIM DDIG	00	COMPLETED
		155448	A. BUILDING B. WING  00  05/12/2011		
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	8	I	CHIGAN ST	
LOWELL HEALTHCARE CENTER			LL, IN46356		
			LOWE		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
				1	
		r the Investigation of	F0000		
	Complaint IN000	089914.			
	Complaint IN000	089914-Substantiated.			
	•	iciencies related to the			
		ited at F281 and F333.			
	unegations are er	100 at 1201 and 1333.			
	Cumusus datas M	In 11 % 12 2011			
	Survey dates. M	Iay 11 & 12, 2011			
	Facility number:				
	Provider number	:: 155448			
	AIM number: 10	00266340			
	Survey team:				
	Janet Adams, RN	N. TC			
	Kathleen Vargas,				
	Radificen vargus,	, 10. (3/12/11)			
	Canqua had tuma				
	Census bed type:	•			
	SNF/NF: 69				
	Total: 69				
	Census payor typ	pe:			
	Medicare: 12				
	Medicaid: 47				
	Other: 10				
	Total: 69				
	Sample: 6				
	Sample. 0				
	There deficies to	and at atota for the co			
		es reflect state findings			
	cited in accordan	nce with 410 IAC 16.2.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

R61D11

Facility ID:

000361

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155448	B. WING		05/12/2011	
NAME OF PROVIDER OR SUPPLIER  LOWELL HEALTHCARE CENTER		710 M	T ADDRESS, CITY, STATE, ZIP CODE MICHIGAN ST ELL, IN46356			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	` .	ompleted 5/17/11 by				
	Jennie Bartelt, R					
F0281 SS=D		ided or arranged by the professional standards of				
	Based on recor	rd review and	F0281	Submission of this Plan of	06/03/2011	
	interview, the	facility failed to		Correction does not constitute admission or agreement by		
	provide servic	•		provider of the truth of facts		
	_	andards of quality		alleged or corrections set forth on		
	•	following the five		the statement of deficiencies This Plan of Correction is	<b>)</b> .	
		administration for 1		prepared and submitted bec	ause	
				of requirements under State		
		the sample of 6		Federal law. Please accept to plan of correction as our cre		
		nedication errors,		allegation of compliance. F2	I	
		an insulin injection		Services Provided Meet		
	that was order	ed for another		Professional Standards 1.  Resident #B's insulin was		
	resident. (Resi	dents #B and #C)		administered according to the physician order. Resident #	• • • • • • • • • • • • • • • • • • •	
	Findings include:			was evaluated by the nurse practitioner. Resident #C was monitored for adverse reacti	I	
	The "Drug Ad	ministration		All residents receiving ins were reviewed with the nurs	sulin	
	Guidelines" in	the "2010 Nursing		ensure the correct residents		
	Spectrum Drug	g Handbook" were		received the correct insulin.		
	_	e guidelines indicated		other residents were affected 3. All nursing staff were	u.	
	nurses were re	-		re-educated regarding the 5		
		five rights" of drug		of medication administration		
		The five rights		Medication passes were observed by the D.O.N. and	/or	
		ing medications were		designee. No other medicati	ion	
		<del>-</del>		errors were found during the		
	administered to	o the right patient by		observations. 4. Medication	۱	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155448			(X2) MUI  A. BUILE  B. WING	DING	NSTRUCTION  00	(X3) DATE: COMPL 05/12/2	ETED
NAME OF PROVIDER OR SUPPLIER LOWELL HEALTHCARE CENTER			p. wind	STREET A	DDRESS, CITY, STATE, ZIP CODE CHIGAN ST L, IN46356		
	HEALTHCARE CEI  SUMMARY S (EACH DEFICIENT REGULATORY OR CONFIRMING the Teviewed on 5.7 The resident's but were not lid disease, hypothelio blood pressure and chronic air. The resident diagnosis of diagnosis of diagnosis of diagnosis of diagnosis of diagnosis or or (medications or or (medications to levels).  A "Medication completed on 2 on 5/12/11 at 1 indicated Residing control of 15.8 diagnosis of 15.8 diagnosis of 15.8 diagnosis of 15.8 diagnosis or or (medications to levels).	NTER  TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Patient's identity.  Resident #C was /11/11 at 5:00 p.m. diagnoses included, mited to, Alzheimer's hyroidism, high e, depressive disorder, rway obstruction.		STREET A	CHIGAN ST	on ay, veeks be be y the cess. to 5.	(X5) COMPLETION DATE
	on 2/4/11 at 3: physician was	in injection was given 55 p.m. The notified on 2/4/11 at lers were obtained on					

000361

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155448		(X2) MULTIPLE CC A. BUILDING B. WING	00	i i	E SURVEY PLETED 2011	
NAME OF PROVIDER OR SUPPLIER  LOWELL HEALTHCARE CENTER			710 MI	ADDRESS, CITY, STATE, ZIP CHIGAN ST .L, IN46356	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
TAG	2/4/11 to check sugar levels ex 10:00 a.m. on When intervies 11:20 a.m., the Nursing indicated the 2/4/11 Med. The Assistant indicated the sadministered to the wrong resist medication error after it occurred. When intervies 1:40 p.m., the indicated staff "Rights of Med. Administration administering which include medication to Director of Nu facility protocol."	k the resident's blood very two hours until 2/5/11.  wed on 5/12/11 at e Assistant Director of ated she completed dication Error Report. Director of Nursing taff nurse who he insulin injection to dent reported the for to her immediately ed.  wed on 5/12/11 at Director of Nursing are to follow the dication	TAG			DATE
	their picture ir	the medication sking another staff				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155448		(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 05/12/2011	
NAME OF PROVIDER OR SUPPLIER  LOWELL HEALTHCARE CENTER			710 MIC	ADDRESS, CITY, STATE, ZIP CODE CHIGAN ST .L, IN46356	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0333 SS=D	free of any significate Based on recommendate, the ensure resident significant me related to an in Humulin 70/30 ordered by the administered to reviewed for in the sample of the sample of the sample of the sample of the record for reviewed on 5. The resident's but were not lidisease, hypotheliood pressure.	nsure that residents are ant medication errors. rd review and facility failed to ts were free of dications errors insulin injection of 0 insulin that was not a physician was of 1 of 1 resident inedication errors in 6. (Residents #B and	F0333	F333 Residents Free of Significant Med Errors 1. Resident #B's insulin was administered according to the physician order. Resident # was evaluated by the nurse practitioner. Resident #C was monitored for adverse reactions. All residents receiving insure the correct residents received the correct insulin. Other residents were affected. All nursing staff were re-educated regarding the 5 of medication administration. Medication passes were observed by the D.O.N. and designee. No other medication representations will be completed and documented various shifts, Monday -Fridathree times a week for two was then visual observations will completed weekly ongoing to D.O.N. and/or designee. Medication observation will part of the ongoing QA proced the findings will be reported.	as ons. sulin e to  No d. rights  /or on e n on ay, //eeks be by the

000361

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO	NSTRUCTION	(X3) DATE SI COMPLE	
AND PLAIN	OF CORRECTION	155448	A. BUI		00	05/12/20	
		100110	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/12/20	
NAME OF PROVIDER OR SUPPLIER				1	CHIGAN ST		
LOWELL HEALTHCARE CENTER				1	L, IN46356		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
	The resident d	id not have a			the QA committee quarterly.	5.	
		abetes mellitus.			These systemic changes we	re	
	and sies is er as				completed on 2/8/11.		
	The 2/2011 ph	ysician's orders					
	indicated were	no orders for the					
	resident to reco	eive any insulin					
		ral hypoglycemic					
	-	o lower blood sugar					
	`	sician's order was					
	,	11 at 5:00 p.m. for					
		the resident's blood					
		wo hours until 2/5/11					
	at 10:00 a.m.	WO 110415 411411 2/3/11					
	at 10.00 a.m.						
	A Physician Pr	ogress Note					
	-	2/4/11 indicated the					
	•	oner was asked to					
	evaluate the re	sident as the resident					
		e of insulin. The					
		indicated the the					
	-	d sugar immediately					
	afterwards was "250's" and did drop to "50's."						
	10 50 s.						
	   The 2/2011 Ni	rsing Progress Notes					
		. An entry on 2/4/11					
		dicated new orders					
	_	from the Nurse					
		An entry at 10:00 p.m.					
	Tractitioner. F	m chuy at 10.00 p.m.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155448			(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE COMPL	ETED
NAME OF PROVIDER OR SUPPLIER  LOWELL HEALTHCARE CENTER			'	710 MIC	DDRESS, CITY, STATE, ZIP CODE CHIGAN ST L, IN46356	•	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
		Nurse Practitioner and assessed the					
	completed on on 5/12/11 at indicated Resi injection of 15 70/30 that was #B. The insul on 2/4/11 at 3: physician was 4:00 p.m. Ord 2/4/11 to check sugar levels ex 10:00 a.m. on	notified on 2/4/11 at lers were obtained on k the resident's blood very two hours until 2/5/11.					
	11:20 a.m., the Nursing indica the 2/4/11 Med The Assistant indicated the sadministered the reported the manner.	wed on 5/12/11 at e Assistant Director of ated she completed dication Error Report. Director of Nursing taff nurse who he insulin injection hedication error to her fter it occurred.					
	When intervie	wed on 5/12/11 at					

AND PLAN OF CORRECTION IDENTIF		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155448	(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 05/12/2011
NAME OF PROVIDER OR SUPPLIER  LOWELL HEALTHCARE CENTER			STREET A	ADDRESS, CITY, STATE, ZIP CODE CHIGAN ST .L, IN46356	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
		Director of Nursing are to follow the 6			
	indicated staff "Rights of Media Administration administering which includes medication to Director of Nu facility protocoto identify the their picture in books, or by as member.	are to follow the 6 dication			